

MEASURE *Evaluation* Bulletin

Number 1, 2000



MONITORING THE QUALITY OF CARE IN FAMILY PLANNING



Quick Investigation of Quality (QIQ): Monitoring quality of care in clinic-based family planning programs <i>by Jane Bertrand and Tara Sullivan</i>	1
Assessing the quality of care of NGO family planning services in Ecuador <i>by Amparo Gordillo and Ernesto Pinto</i>	5
Quick Investigation of Quality (QIQ) provides data for family planning and reproductive health program monitoring in Turkey <i>by Ersin Topcuoglu and Siân Curtis</i>	9
The quality of family planning and antenatal care services in DISH and comparison districts in Uganda <i>by Ruth E. Bessinger and Charles Katende</i>	13
Quick Investigation of Quality (QIQ) in SEATS-supported family planning clinics in Zimbabwe <i>by Meghan McCarrier, Irene Moyo and Tim Williams</i>	17
Does contraceptive discontinuation matter? <i>by Ann Blanc, Siân Curtis, and Trevor Croft</i>	21

Editorial Note

The MEASURE *Evaluation* project focuses on developing new tools and methods for monitoring and evaluating population, health and nutrition programs. The project publishes technical reports and working papers to share findings from its work in this field. The MEASURE *Evaluation* Bulletin was started to reach a broader audience, including policy makers, planners, program staff and evaluation specialists in the field of international health and population. At least four issues will be published each year. Each issue contains a number of articles that focuses on a common topic. The first issue is on monitoring the quality of care in family planning. The next two issues will cover monitoring and evaluation tools for AIDS programs and care and on the use of program effort scores in the fields of family planning, maternal health and AIDS.

While getting services to the people was one of the main pre-occupation of health services delivery during the last decades, attention has shifted towards the role of the quality of services provided in health care settings. In this issue, five articles are devoted to the development and application of a new rapid method to monitor the quality of care in family planning: Quick Investigation of Quality (QIQ – pronounced as Quick). Although QIQ focuses on family planning, it can easily be adapted to include other services, such as post-partum or post-abortion services (see Turkey article in this issue) and antenatal care (see Uganda article in this issue). The emphasis is on monitoring, which implies that repeated investigations using the same approach and tools are required on a regular basis. Such investigations, for example, are currently being done in Istanbul, Turkey, where the 1998 survey was followed up by a QIQ in 2000.

The sixth article of the Bulletin concerns contraceptive discontinuation, which is often cited as an outcome associated with the quality of care provided by family planning programs. Contraceptive discontinuation data are obtained from individual interviews and not related to a QIQ. Based on an analysis of DHS surveys the authors suggest that all-method discontinuation rates can partly be used to indicate and monitor the quality of care in family planning.



The MEASURE *Evaluation* Bulletin is made possible by support from USAID under the terms of Cooperative Agreement HRN-A-00-97-00018-00. The opinions expressed are those of the authors, and do not necessarily reflect the views of USAID.

Quick Investigation of Quality (QIQ): Monitoring quality of care in clinic- based family planning programs *by Jane Bertrand and Tara Sullivan*

- ✓ **The QIQ was developed to address the need for a practical, low-cost methodology for measuring quality of care in clinic-based family planning programs.**
- ✓ **Twenty-five indicators were selected after a broad process of consultation.**
- ✓ **The QIQ can easily be adapted to local needs and administered with relatively few problems.**

The Quick Investigation of Quality (QIQ) was developed in response to the need for a low-cost, practical tool to routinely monitor quality of care in clinic-based family planning programs [1]. There were three steps in the development of the tools: (1) selection of indicators, (2) development of protocol and data collection instruments, and (3) field testing [2,3].

Selection of indicators

There are literally hundreds of indicators that can be used to measure quality. Since the volume of data that can be generated in the name of measuring quality can be overwhelming, a decision was made to reach a consensus on 25 quality of care indicators (Table 1). The assumption was that facilities performing well on the key (benchmark) indicators would most likely also perform well on similar indicators not measured by the instruments.

Development of instruments

Three methods of data collection were selected to assess the quality of care: facility audit, observation and client exit interview. The facility audit includes an interview with the health workers and an inventory of basic equipment, medicines and contraceptives. Observation is used to assess the quality of provider-client interaction. Client exit interviews provide further information about the quality of the provider-client interaction and also provide information about the satisfaction of the client with the services. Each instrument provides a unique view-

point of the quality of care delivered at a facility. It is recommended that all three instruments be used to obtain the most comprehensive assessment of quality.

Field test

The data collection instruments were field tested in four countries: Ecuador, Turkey, Uganda, and Zimbabwe. A few concerns arose during the administration of the QIQ: (1) The reliability of observations and the effect of the observer's presence, (2) recall and courtesy biases in the client exit interview, and (3) the long list of items to be counted in the facility audit. As a solution to this last concern, interviewers from all four countries suggested documenting the presence of one of each type of item instead of counting every piece of equipment.

Sampling of facilities

The specific sampling strategy of QIQ may vary from country to country, depending upon the goal of the assessment. In the QIQ user's manual, several key sampling scenarios have been identified and are explained in detail in the sampling guidelines section [3]. These scenarios include monitoring of a national family planning program, monitoring of a specific targeted project, and a comparison of intervention and non-intervention areas. In Ecuador and Zimbabwe, there was a census of a given type of facility; in Turkey, a census of facilities in a given metropolitan area; and in Uganda, a comparison of intervention and non-intervention clinics.

Table 1. Short list of indicators and instruments

Indicator	Instruments
Demonstrates good counseling skills (composite)	C,O
· Assures client of confidentiality	O
· Asks client about reproductive intentions (more children? when?)	C,O
· Discusses with client which method she would prefer	C,O
· Mentions HIV/AIDS (initiates or responds)	C,O
· Discusses dual method use	C,O
· Treats client with respect/courtesy	C,O
· Tailors key information to the particular needs of the specific client	C
· Gives accurate information on the method accepted (how to use, side effects, complications)	C,O
· Gives instructions on when to return	C,O
Follows infection control procedures outlined in guidelines	O
Recognizes/identifies contraindication consistent with guidelines	O
Performs clinical procedures according to guidelines	O
Staff (other than provider)	
Treat clients with dignity and respect	C
Client	
Participates actively in discussion and selection of method (is "empowered")	C,O
Receives her method of choice	C,O
Client believes the provider will keep her information confidential	C

Indicator	Instruments
Facility	
Has all (approved) methods available; no stockouts	F
Has basic items needed for delivery of methods available through SDP (sterilizing equipment, gloves, blood pressure cuff, specula, adequate lighting, water)	F
Offers privacy for pelvic exam/IUD insertion (no one can see)	C,O,F
Has mechanisms to make programmatic changes based on client feedback	F
Has received a supervisory visit in past __ months	F
Adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premises	F
Has state-of-the-art clinical guidelines	F
Waiting time is acceptable	C,F

C = Client Exit Interview
O = Observation
F = Facility Audit

Table 2. Cost of field work by country

Country	Number of facilities	Cost of fieldwork	Cost per facility
Ecuador	43	\$46,000	\$1070
Turkey	128	\$33,000	\$258
Uganda	72	\$65,000	\$903
Zimbabwe	39	\$19,000	\$487
Mean	71	\$40,750	\$680

Is the QIQ “practical and low-cost?”

The original mandate behind the QIQ was to develop a practical, low-cost methodology for monitoring quality of care in family planning services in developing countries. Overall, the instruments were judged to be practical by those who administered them. That is, it was possible to train field test personnel, pre-test the instruments, conduct the fieldwork, and process the data with relatively few problems. However, as to its being a “low-cost methodology,” the response was mixed. At the presentation of findings to colleagues in April 1999, researchers indicated that the price tag was reasonable in comparison to similar efforts. Service providers, however, considered it expensive. Data on the cost of the field test in the four countries are presented in Table 2. These costs do not include technical assistance and local dissemination. There is considerable variation between the countries, which in part is due to the location of the facilities. In Turkey, where costs per facility were lowest, the fieldwork was located in one province.

Notes

[1] The QIQ was developed with support from the USAID Office of Population, and spearheaded by the MEASURE *Evaluation* Project in collaboration with the Monitoring and Evaluation Subcommittee of the MAQ (Maximizing Access and Quality) initiative. Numerous USAID cooperating agencies contributed to the identification of a “short list” of indicators.

[2] MEASURE *Evaluation* Project. 2000. *Quick Investigation of Quality (QIQ): A User’s Guide for Monitoring Quality of Care*. Chapel Hill, North Carolina: Carolina Population Center.

[3] *Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports*. MEASURE *Evaluation* Technical Report Series No. 5. Sullivan, Tara M. and Bertrand, Jane T. (Editors). Carolina Population Center, University of North Carolina at Chapel Hill, June 2000.

Assessing the quality of care of NGO family planning services in Ecuador

by Amparo Gordillo and Ernesto Pinto

- ✓ **The Quick Investigation of Quality (QIQ) field test indicates generally high level of quality of care in NGO facilities.**
- ✓ **Facilities are prepared to deliver reversible contraceptive methods.**
- ✓ **Providers scored high on counseling skills, but need to discuss HIV/AIDS and STD prevention more often.**
- ✓ **Clients are, overall, satisfied with services received.**

A survey of the quality of care at NGO facilities in Ecuador was conducted as part of the Quick Investigation of Quality (QIQ) field test. The two major NGOs in Ecuador, *Asociación Pro-bienestar de la Familia Ecuatoriana* (APROFE) and *Centro Médico de Orientación y Planificación Familiar* (CEMOPLAF), operate a total of 43 health facilities in urban areas. A facility audit was performed at all 43 facilities. Two types of providers — doctors and *obstetrices*/nurses — were observed, and client exit interviews were conducted at each facility [1]. Data were collected during a single day at each facility [2].

Facility audit

The facility audit instrument assessed the infrastructure and availability of equipment and supplies for the effective delivery of contraceptive methods.

Eighty-eight percent of facilities provided only outpatients services; 12% provided surgical procedures as well. All but one facility had mechanisms for client feedback. Slightly fewer than half of the facilities had received a supervisory visit in the past six months. The average client waiting time was 50 minutes.

In nearly all of the facilities, essential equipment and supplies were available. There were education materials on family planning in just over half of the facilities. All facilities had pills, IUD and injectables in stock, but only 44% had spermicides (Figure 1). The availability of surgical methods (female steril-

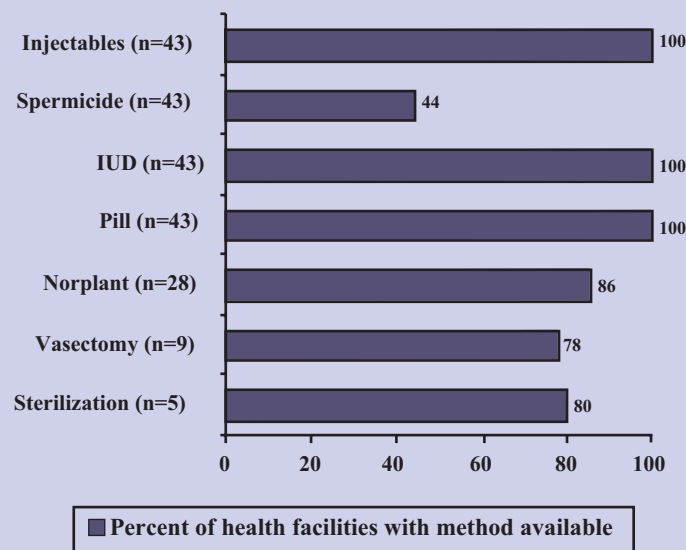
ization or vasectomy) fell short of expectations in three clinics. Several reasons were given for not offering long-term methods in designated clinics, including the absence of trained personnel for vasectomy and Norplant procedures. In one case, the health facility (originally designed to offer all surgical procedures) determined that it was not cost-effective to offer surgical methods. The NGOs' policy is to offer surgical services only if the necessary maintenance costs can be justified. The providers may refer clients to another facility within or outside the network for surgical procedures.

Observation of client-provider interaction

The analysis of the client-provider observation compared the performance of physicians to that of *obstetrices*/nurses in two areas: counseling skills and compliance with clinical procedures. In CEMOPLAF and APROFE facilities, family planning clients meet with health counselors before they are seen by a clinical service provider. Consequently, the results for the observation may be incomplete, as some items may have been covered in this initial counseling session before the client saw the provider. Ideally, counseling sessions with a client counselor should be included in the quality assessment to provide the complete client-provider interaction.

On the whole, both types of providers scored well on quality of counseling skills. Figure 2 shows the scores of the seven provider actions observed for all clients. In general, there was a favorable climate for asking questions and voicing concerns.

Figure 1. Availability of contraceptive methods



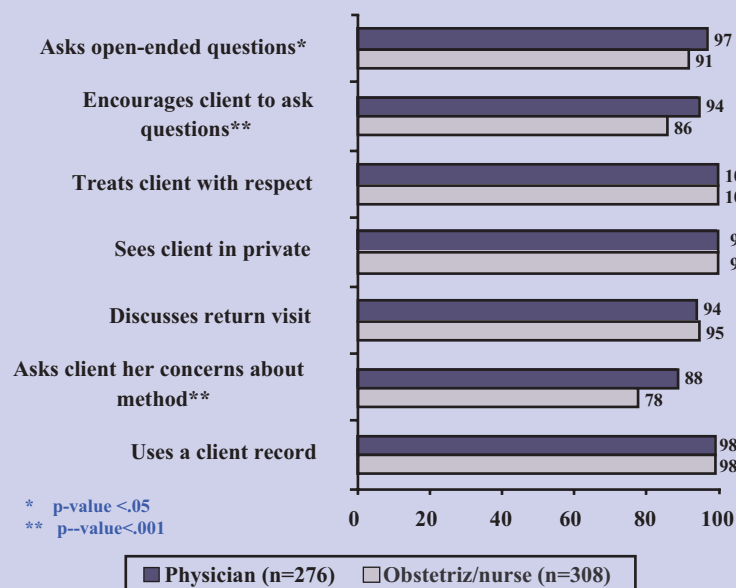
The scores on counseling of new clients were slightly lower, and somewhat poorer for *obstetricians/nurses* than for physicians. For instance, 74% of physicians and 66% of *obstetricians/nurses* explained the side effects of the method selected.

Another shortcoming of both types of clinical service providers was the coverage of HIV/AIDS and STDs. Because information related to sexual behavior and HIV/AIDS is generally not discussed between client and provider, providers tend not to inquire about multiple sexual partners and STDs and HIV/AIDS. No more than 20% of doctors or *obstetricians/nurses* inquired about these issues. Doctors and *obstetricians/nurses* scored very low on “explaining that the method does not protect against STDs/AIDS” and “encourages use of condoms as a second method.” These topics were covered in no more than 20% of the counseling sessions. According to managers, this type of information is generally only addressed in select cases and is also not discussed on a regular basis due to low HIV prevalence in Ecuador.

The observation of clinical procedures included direct observation of three types of clinical procedures: injections, pelvic exams and IUD insertions. Both types of providers demonstrated a high level of compliance with recommended clinical procedures for all three procedures, with one exception, washing hands before each procedure.

Although hand washing should occur in 100% of the cases, in practice it was done in only 67% to 72% of the cases.

Figure 2. Provider actions during counseling sessions by type of provider



* p-value <.05
** p-value <.001

Client exit interview

Exit interviews with family planning clients showed that clients were generally satisfied with the services they received. Over 80% of the clients across all age groups reported that (1) they felt comfortable asking questions, (2) they received the right amount of information, (3) there was adequate privacy, and (4) the waiting time was reasonable. In addition, the majority of new clients reported that providers showed them how to use their method (97%), informed them about its side effects (81%), and told them what to do in case of side effects or complications (76%).

Clients who received their preferred method were more likely to be satisfied. In the Ecuador field test, the discussion of a client’s preferred method differed by age group. Younger patients seem to receive special attention from providers. All new clients between 15 and 19 years of age discussed their preferred method

and other contraceptive methods with the provider. Ninety percent of these clients received their preferred method.

In contrast, while 97% of the 20- to 29-year-olds discussed their preferred contraceptive method and other contraceptive methods with the providers, only 76% of this group received their preferred method. The primary reasons for not receiving the preferred method were that the contraceptive method was not appropriate and that the provider recommended another method.

Only 64% of the oldest group of new clients (30 to 49 years of age) reported receiving their preferred method. This is not surprising, since these clients often seek contraceptive methods that are no longer appropriate for them at their age. In fact, 53% of clients in this group reported either that the provider advised them against the method they had initially selected or that the provider recommended another method.

Programmatic implications

Generally, the field test indicated that CEMOPLAF and APROFE have respectable levels of quality of services. QIQ findings suggest that it would be useful to

- review the counseling guidelines used at the facilities with the aim of better integrating the activities of clinical service providers and counselors in counseling new and follow-up clients

- encourage counselors and other health professions to provide information on HIV/AIDS to their clients during counseling sessions, given the growing spread of the epidemic in the country
- promote continuous education for clinical service providers in infection control and clinical procedures
- create a committee at each clinic to develop mechanisms to identify suggestions for making quality improvements and strategies to carry them out
- maintain continuous monitoring of quality of care throughout the network of clinics

Notes

[1] *Obstetrices* are health professionals trained at the graduate level (non-MD) to address women's health issues, including attending births.

[2] Gordillo, A and Pinto, E. "Ecuador Family Planning: Quick Investigation of Quality." In *Monitoring Quality of Family Planning Services by the Quick Investigation of Quality (QIQ): Country Reports*. MEASURE Evaluation Technical Report Series No. 5. Sullivan, Tara M. and Bertrand, Jane T. (Editors). Carolina Population Center, University of North Carolina at Chapel Hill. July 2000.

Quick Investigation of Quality (QIQ) provides data for family planning and reproductive health program monitoring in Turkey
by Ersin Topcuoğlu and Siân Curtis

- ✓ **In Istanbul Province, the QIQ was used to assess the quality of family planning and post-abortion care.**
- ✓ **The QIQ provided baseline data for monitoring the reproductive health program.**
- ✓ **Program strengths: at least three modern methods of contraception were offered by all private hospitals, 97% of the MCH/FP centers, and more than 80% of public hospitals.**
- ✓ **Program weakness: only 41% of health centers offered at least three modern methods of contraception.**
- ✓ **The QIQ methodology is now integrated into USAID/Turkey's performance monitoring plan.**

The USAID/Turkey reproductive health program emphasizes the expansion of high quality family planning/reproductive health (FP/RH) services [1]. To monitor the program's progress, a series of indicators had been selected, and a low-cost, rapid assessment tool was needed to collect the relevant data. The QIQ methodology was implemented in the USAID/Turkey focus province of Istanbul in October 1998 [2]. The standard QIQ instruments were adapted to meet program monitoring needs. The instruments used in Turkey included a facility inventory and exit interviews with family planning clients and with post-abortion and post-partum clients in hospitals providing those services. No client-provider observations were conducted.

Availability of IEC materials

A lot of program effort has been put into preparing high-quality, up-to-date informational materials for use by family planning providers and their clients. The Istanbul QIQ indicated that more than half of all public facilities of all types had the National FP Guidelines and the FP pocket book (Table 1). At public facilities, National Guidelines, FP pocket books, and

Turkey QIQ

Facilities

52 health centers
32 MCH/FP centers
21 public hospitals
23 private hospitals

Clients

928 family planning
480 post-partum
74 post-abortion

Table 1. Percentage of facilities with specific IEC materials available

IEC Materials	Hospitals			Outpatient Clinics	
	Public MOH	Public SSK	Private	MCH/FP Centers	Health Centers
National FP guidelines	64	86	17	84	50
FP pocket guide	57	71	13	78	60
FP flip-book	43	71	26	84	44
Appropriate brochures	21	57	39	50	12
GATHER poster	21	43	4	34	2

SSK: Social Security Organization

FP flip-books were found more frequently than were complete sets of brochures and GATHER posters.

Method choice and information

Programs in Turkey strive to ensure that clients receive a thorough explanation of all available contraceptive methods. Program activities also focus on increasing clients' knowledge of the method they eventually choose. The QIQ indicated that all private hospitals and 97% of the MCH/FP centers in the Istanbul QIQ either provided or prescribed at least three modern methods, as did over 80% of public hospitals. In contrast, only 41% of health centers provided or prescribed at least three modern methods.

During the exit interviews, clients were asked a number of questions to assess their knowledge of their method. Knowledge was lowest among injectable users and highest among IUD users (Figure 1). The percentage of clients who were able to correctly answer all questions on their method ranged from 5% for pill users to 17% for IUD users.

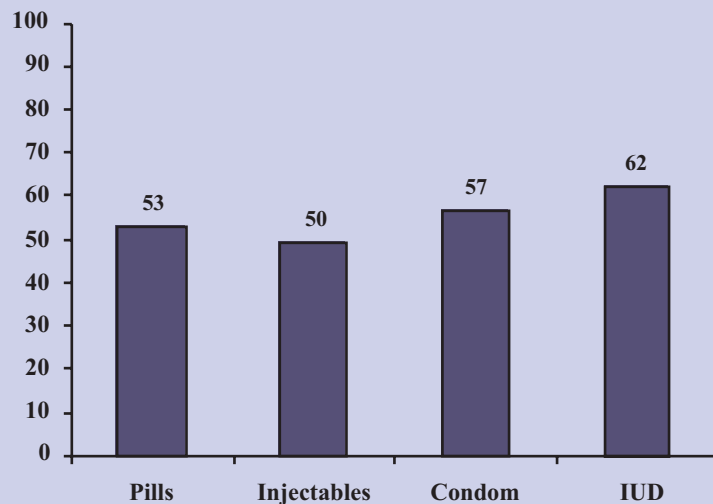
Post-abortion and post-partum FP

Another priority area in the Turkey program is increasing the availability of post-abortion and post-partum family planning services. Two-thirds of abortion clients reported that they received pre-abortion FP counseling, and 63% adopted a modern contraceptive method after the abortion (Figure 2). Only 27% of post-partum clients received FP counseling prior to discharge, and only 9% of clients received a method or an appointment for a method.

Other highlights

- *Infrastructure:* Most facilities have a waiting area in or near the FP unit and an accessible toilet with running water and electricity. While most of the hospitals and MCH/FP centers had separate rooms for FP services, almost half of the health centers did not.
- *Contraceptive storage:* 83% of facilities had adequate contraceptive storage conditions.
- *Stock-outs:* Stock-outs of contraceptives are fairly common in public hospitals, but are less common in health centers. Forty percent of health centers and nearly three-fourths of Ministry of Health hospitals reported stock-outs of condoms in the preceding six months.
- *Infection prevention:* Only 21% of facilities met all of the four infection prevention standards.
- *Supervision:* Nearly 90% of MCH/FP centers had been visited by a supervisor in the preceding six months. However, only 31% of health centers and 21% of the Ministry of Health hospitals had received a supervisory visit.
- *Visibility:* Only 17% of facilities surveyed had permanent signs inside and outside the building and on the main door to indicate the availability of FP services.
- *Client satisfaction:* At least two-thirds of clients in all types of facilities reported that they were seated, had sufficient time with the provider, and clearly understood the information provided.

Figure 1. Mean percentage of knowledge questions answered correctly among users by method



Conclusions

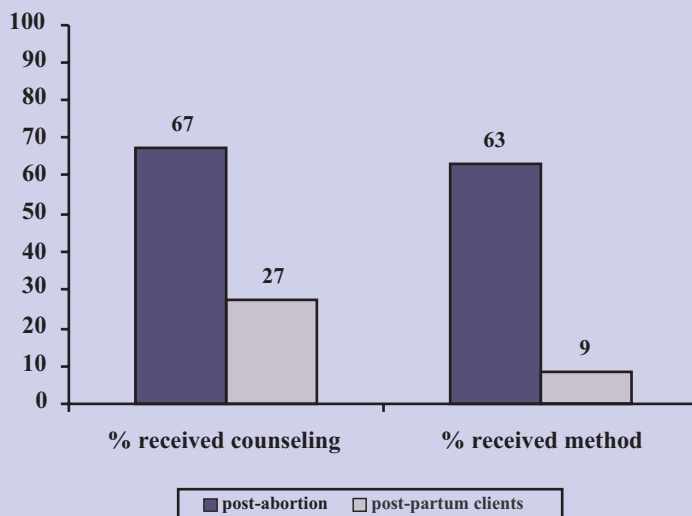
The Istanbul QIQ provided valuable baseline information for monitoring the USAID/Turkey FP/RH program. The results of the Istanbul QIQ have been used extensively to redefine program priorities and direct limited resources. In the context of the Turkey program, the methodology has proved low-cost and practical to implement. The QIQ methodology has become an integral part of the USAID/Turkey performance monitoring plan. Following successful implementation of the survey in Istanbul, it has been used to provide baseline data for new programs in two other provinces in Turkey. A second survey was completed in Istanbul in May 2000 to monitor progress on the indicators developed. The use of handheld computers for field data entry in the more recent surveys has further increased the efficiency of the survey, and has facilitated rapid feedback of the results to facility and program managers.

Notes

[1] Turkey: Quick investigation of quality of family planning, post-partum and post-abortion services." In *Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports*. MEASURE Evaluation Technical Report Series No. 5. Sullivan, Tara M and Bertrand, Jane (Editors). Carolina Population Center, University of North Carolina at Chapel Hill, June 2000.

[2] Topcuoğlu, Ersin and Hulki, M. Family planning quality survey. Istanbul 1998. Report. Ministry of Health, Republic of Turkey, and Management Sciences for Health. Ankara. December 1999.

Figure 2. Post-abortion and post-partum family planning services



The quality of family planning and antenatal care services in DISH and comparison districts in Uganda

by Ruth E. Bessinger and
Charles Katende

- ✓ **The Quick Investigation of Quality (QIQ) showed a fairly adequate level of care in DISH and in comparison districts. Several indicators scored better in DISH districts than in non-DISH districts.**
- ✓ **Most family planning and antenatal clients were satisfied with the services received.**
- ✓ **More new family planning clients received their preferred method in DISH districts than in comparison districts.**
- ✓ **Family planning and antenatal clients in DISH districts were more likely to have their problems addressed than in comparison districts.**
- ✓ **Integration of STD and HIV prevention activities into antenatal visits occurred more frequently in DISH districts than in comparison districts.**

A survey of the quality of care of family planning and antenatal care services was conducted in Uganda as part of the field test of the Quick Investigation of Quality (QIQ), in collaboration with the Delivery of Improved Services for Health (DISH) project. This project aims to improve the quality, use, and sustainability of reproductive health services in 12 of Uganda's 45 districts. One objective of the survey was to compare the quality of care in DISH project and non-project districts for program evaluation and improvement [1,2]. Observations of client-provider interaction and exit interviews with clients were used to obtain information about the quality of care.

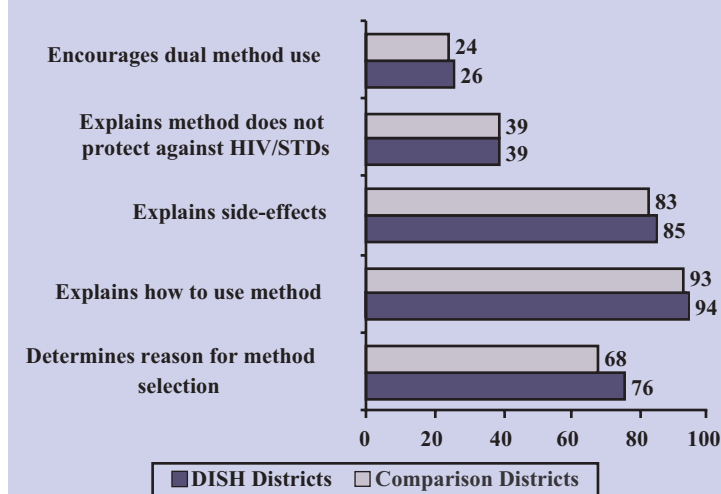
New family planning clients

New family planning clients received information on a wide variety of family planning methods during the course of the visit. Over 90% of clients received information on the injectable and the pill. More new clients in DISH districts reported receiving information on Norplant (61% vs. 32%) and condoms (75% vs. 59%) than those in comparison districts. The injectable was the preferred method for 67% of new clients in DISH

Uganda QIQ

	DISH	Comparison
Districts	10	3
Health Facilities	50	22
FP Clients	380	160
New FP Clients	91	51
FP Providers	251	82
Antenatal Clients	420	259

Figure 1. Provider actions with new family planning acceptors



districts and 53% of new clients in comparison districts. Of those new clients who had initially expressed a preference, a significantly greater percentage in DISH districts (79% vs. 61%) received their preferred method. In DISH districts, among those new clients who received a method, 77% received the injectable and 19% the pill. Few new clients received or were referred for permanent methods, even though 48% of new family planning clients reported that they did not want more children.

In almost all encounters with new family planning clients, the provider gave the client accurate information on how to use the selected method, and in 85% of instances, information on the potential side effects of the method (Figure 1). Most clients went home with the method they asked for. Fewer than half of the new clients who accepted methods other than condoms were either told that the method would not protect against HIV infection or STDs, or encouraged to use condoms in conjunction with the chosen method. There were no significant differences between provider actions with new family planning acceptors in DISH and comparison districts.

Provider competence in family planning

Most family planning users attending a follow-up visit indicated the provider had asked about method problems: 87% in DISH districts and 83% in comparison districts (Figure 2). While most providers discussed problems experienced with the client, providers in DISH districts were significantly more likely to have offered suggestions for resolving the problem than those in comparison districts (83% of cases vs. 65%). Almost all clients who received advice expressed satisfaction with that advice.

Technical competence, defined as correctly following standard clinical guidelines, was assessed during observation. Compliance with each of the clinical steps was generally high among clients receiving injectables. Two steps in the clinical guidelines — drawing back the plunger before the injection and allowing the dose to self-disperse — were more frequently noted in DISH districts. Overall, however, only 53% of injectables given in DISH districts and 51% given in comparison districts complied fully with clinical guidelines (all six steps conducted correctly).

Provider competence in antenatal care

Providers asked 91% of antenatal clients in DISH districts and 79% of clients in comparison districts whether they were experiencing problems with their current pregnancy. Overall, 53% of clients reported experiencing complications with their pregnancy. In DISH districts, clients experiencing a problem were significantly more likely to be given sugges-

Figure 2. Provider actions for resolution of problems among continuing family planning users

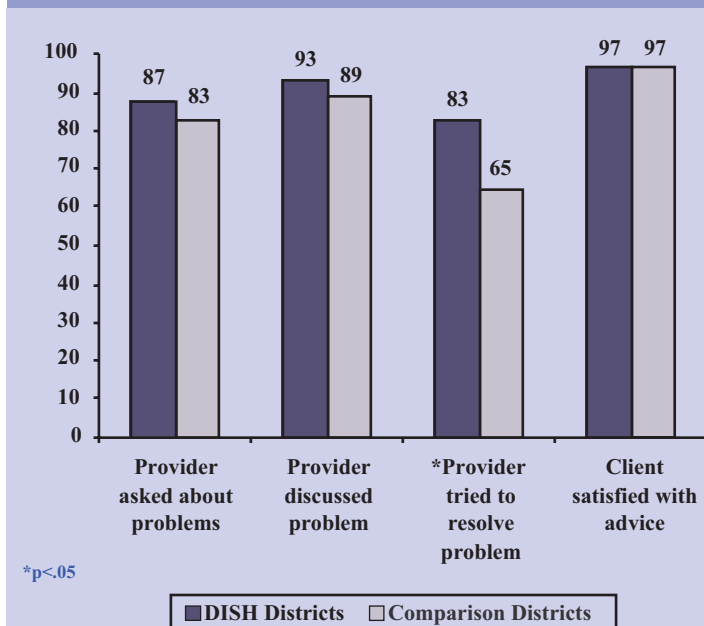
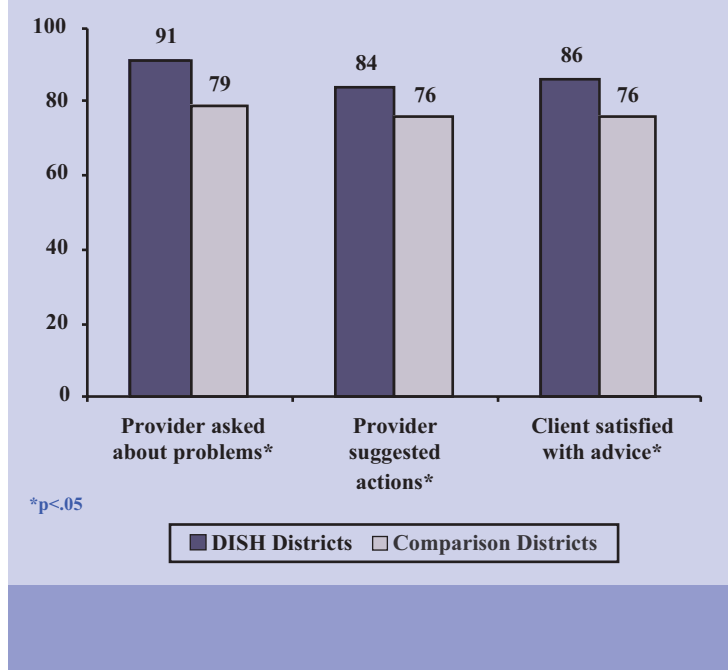


Figure 3. Problem assessment and resolution with antenatal clients



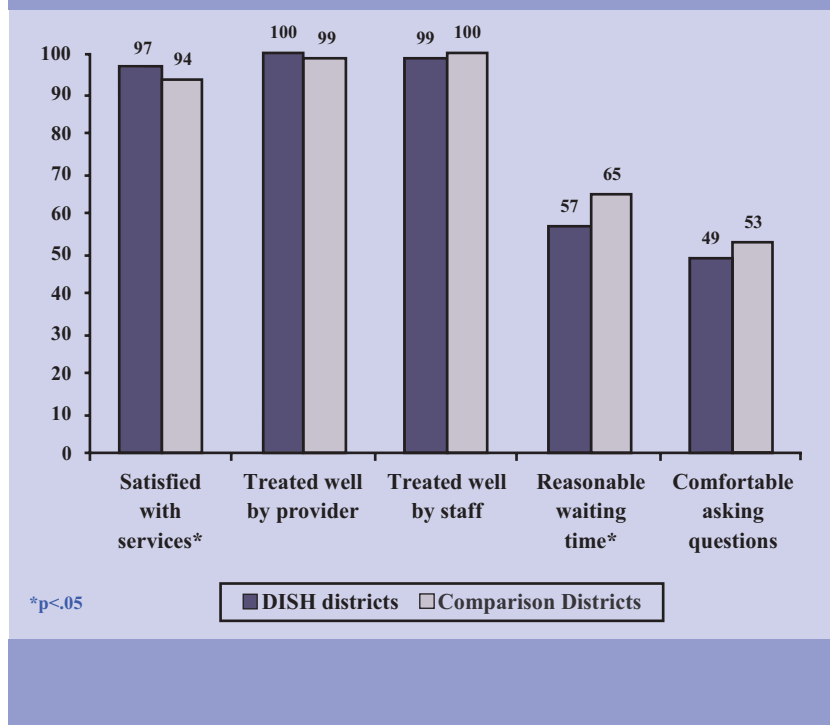
tions for resolving the problem than those in comparison districts (84% vs. 76%). Satisfaction with the advice given was also higher for clients in DISH districts. Eighty-six percent of clients in DISH districts and 76% of clients in comparison districts were satisfied with the advice given (Figure 3).

Clients making their first antenatal visit in DISH districts were more likely to be asked if they had symptoms of an STD than were similar clients in comparison districts. As determined from the observation of the client-provider interaction, 60% of clients in DISH and 45% of clients in comparison districts were asked if they had genital sores. Sixty-seven percent of clients were asked if they had experienced a burning sensation while urinating, and 63% if they had vaginal discharge. Antenatal clients in DISH districts were also somewhat more likely to receive counseling on STD or HIV prevention.

Satisfaction among antenatal clients

Almost all antenatal clients reported being satisfied with services and being treated well by both the provider and other clinic staff (Figure 4). Client satisfaction with services was higher for clients in DISH districts. Although antenatal clients reported that they were treated well by the provider, only about one-half of the clients said that they felt comfortable asking questions, and just over one-quarter actually asked the provider any questions. Many antenatal clients, however, were not satisfied with the waiting time. Forty-three percent of DISH clients and 35% of non-DISH clients said the waiting time was long or too long, and almost a third of clients in both districts waited for over two hours to see the provider. The average time spent with the provider was relatively short. A first antenatal care visit lasted an average of 15 minutes, whereas clients coming for a follow-up antenatal care visit spent 10 minutes with the provider.

Figure 4. Clients' satisfaction with antenatal services



Conclusion

The QIQ tool provided an opportunity to assess the quality of family planning and antenatal care services in selected districts in Uganda. Overall, clients expressed satisfaction with the quality of care received, yet observation of the client-provider interaction indicates that much remains to be done. In comparing quality of care in DISH and non-DISH districts, the greatest differences appear in the area of antenatal care. Perhaps this is due to the fact that in non-project districts, few efforts have been made to improve the quality of antenatal care. Efforts to improve family planning

are much more widespread. As not all of the providers in DISH districts had received training from the project, subsequent analyses need to focus on comparing the quality of care provided by trained and non-trained providers in DISH districts.

Notes

[1] The DISH project is sponsored by the Uganda Ministry of Health and the United States Agency for International Development (USAID). The first phase of the DISH project ran from 1994 to 1999 and was managed by Pathfinder International and its three partner organizations: Johns Hopkins Center for Communication Programs (JHU/CCP), University of North Carolina at Program for Training in Health (INTRAH) and E. Petrich and Associates. This study was a collaborative effort between Pathfinder International and MEASURE *Evaluation*.

[2] Bessinger Ruth E, Katende Charles. “Quick Investigation of Quality of Family Planning and Antenatal Care Services in Uganda.” In *Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports*. MEASURE *Evaluation* Technical Report Series No. 5. Sullivan, Tara M. and Bertrand, Jane T. (Editors). Carolina Population Center, University of North Carolina at Chapel Hill, June 2000.

Quick Investigation of Quality (QIQ) in SEATS-supported family planning clinics in Zimbabwe

*by Meghan McCarrier, Irene Moyo and
Tim Williams*

- ✓ **The QIQ field test indicates a good level of quality in SEATS-supported facilities.**
- ✓ **Facilities were well stocked with contraceptive methods, but lacked some recommended equipment.**
- ✓ **Compliance with infection control procedures was high, with the exception of always washing hands before clinical procedures.**
- ✓ **Providers consistently supplied information regarding proper use and side effects of client's selected method, but neglected to discuss HIV/AIDS issues in most cases.**
- ✓ **Most clients expressed a high degree of satisfaction with services.**

Ensuring quality family planning services has been one of the main objectives of the SEATS Project in Zimbabwe [1]. All 39 facilities that received SEATS support were included in the QIQ study conducted in the next-to-last year of the project. Overall, the study revealed many areas in which quality is acceptably high; however, improvements are still needed in a number of areas. The findings of this field test will be a part of a long-term and ongoing process for improving quality of care.

Facility readiness

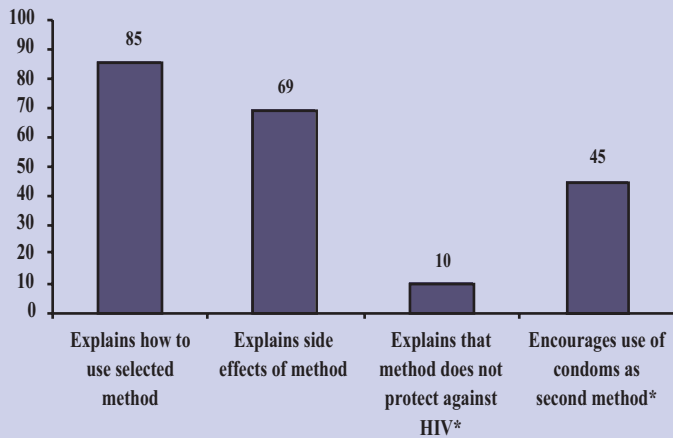
Facilities in Zimbabwe were well prepared to provide high quality family planning services. All facilities surveyed had (1) adequate storage for contraceptives, (2) a private area for pelvic exams and IUD insertions, and (3) an available source of water. Over 85% of all facilities had a sheltered waiting area, a working source of light and clinical guidelines available.

One shortcoming in facility readiness was the availability of essential equipment as defined by international standards.

While 100% of facilities had all the equipment necessary for the provision of the pill, only 8% of the facilities that usually provide injectables had all of the equipment considered necessary to supply them. None of the facilities that usually offer IUDs had all of the recommended equipment for supplying them. Several of these items of equipment on the standards list, however, were unnecessary due to national guidelines that contradict their use. For example, sterilizers are unnecessary because reusing needles is forbidden in Zimbabwe. They were not available at 72% of all facilities that provide injectables. For IUD insertion, the push technique is reported to make the use of sterile gloves unnecessary. Not surprisingly, gloves were not available in 77% of the facilities offering IUDs.

Overall, facilities were well stocked with contraceptive methods. Facilities experienced few stock-outs of the three most often prescribed methods (pills, injectables and condoms). In the past six months, fewer than 5% of facilities had a stock-out of either condoms or pills, and fewer than 13% experienced a stock-out of injectables.

Figure 1. Percent distribution of select provider actions (n=205)



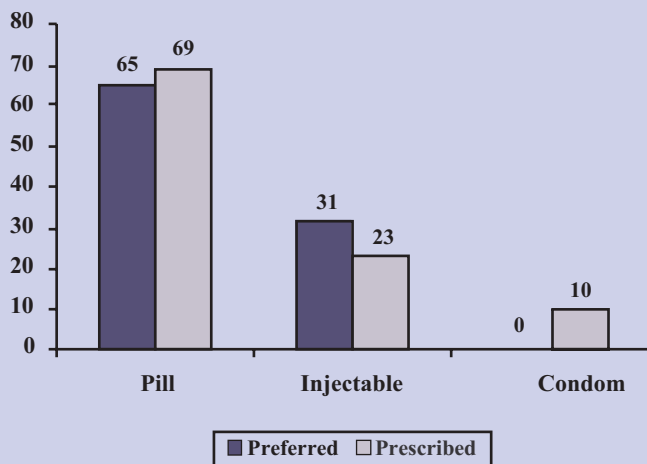
*Calculated for those clients with methods other than condoms

Provider actions

Provider actions fall into two categories — those that affect the quality of medical procedures and those that affect the information or counseling provided to clients. The quality of medical procedures, as measured by compliance with infection control procedures, was generally high with the notable exception of washing hands before the provision of services. Only 6% of providers were observed washing their hands before giving injectables, and 48% of providers were observed washing their hands before performing pelvic exams. One possible explanation for this result is that providers had washed their hands before entering the room in which the observation of client-provider interaction occurred.

Provision of information and counseling was inconsistent. Providers did not provide clients with all necessary information, especially information pertaining to HIV/AIDS (Figure 1). While a high proportion of providers explained to clients how to use their prescribed method, fewer explained the side effects of the method. In addition, only 10% of providers explained to clients that their selected method did not protect against HIV or sexually transmitted infections (STIs). Approximately 45% of providers encouraged the use of condoms as a second method. It was reported, however, that the purpose was to use the condoms as a back-up method of contraception (e.g., if there was any possibility of pregnancy) rather than to protect against HIV/AIDS.

Figure 2. Percent distribution of preference and prescription of three most popular methods* (n=211)



*Other methods preferred include IUD (2.4%), NORPLANT (0.9%), and female sterilization (0.5%). Other methods prescribed include IUD (1.4%).

Client satisfaction

Clients responded positively to most factors reflective of client satisfaction. Over 90% of clients felt comfortable asking questions, felt they were treated well by their provider, believed that the information they provided would remain confidential, and agreed that privacy was adequate during pelvic examinations. Waiting time may be considered a problem. Only 62% of clients reported that waiting time was reasonable.

In addition to being pleased with services, 87% of clients indicated that they received their preferred method (Figure 2), and most were knowledgeable about how to use the method. The pill was the method most often preferred and most often prescribed. Injectables were also often requested and received. Although no clients reported condoms as their preferred method, the method was prescribed to 10% of women. The fact that no women mentioned condoms as their preferred method is cause for concern. This may be due to many reasons, including the stigma attached to requesting condoms, lack of awareness of the risk of HIV/AIDS or the preventive benefits of condoms, women's fear of asking their partners to use condoms, or men's aversion to using condoms.

Also, the low rate of condom distribution by providers must be explored. Providers need proper instruction on how to counsel women on their potential risk of acquiring HIV/AIDS and the role condoms play in preventing the disease. Counseling on condoms for family planning or dual protection may be an effective way to convey this information in a less threatening context than if condoms are discussed only in terms of HIV/AIDS and STI prevention.

Knowledge of how to use their preferred method, as measured by correctly answering a key question about the prescribed method, was over 99% for pill and IUD users, and 92% for injectable users. In contrast, only 82% of condom users correctly answered their key question (“How many times can a condom be used?”).

Conclusion

In most aspects, the facilities in Zimbabwe are prepared to offer satisfactory quality care, and the clients believe that they are receiving good care. The facilities are well stocked and well maintained. Most providers explained how to use the method the client selected, and a very high proportion of clients were knowledgeable about their selected method.

With a severe AIDS epidemic in Zimbabwe, family planning clinics are a potentially effective means of educating women about HIV/AIDS and its prevention; however, very few providers or clients discuss the subject or prescribe condoms to their clients. Approximately 25% of the population are infected with the disease, which in Zimbabwe, is spread primarily through heterosexual contact.

One barrier to educating women on the risks of HIV/AIDS is the provider’s discomfort in discussing the issue with women in apparently monogamous relationships, who, in turn, might find it difficult to discuss condom use with their partners. In the family planning clinic, IEC materials should be designed to make HIV/AIDS a more comfortable topic of conversation to women. In addition, men should be educated about HIV transmission and prevention, including the risks of multiple partners and the benefits of using a condom as both a contraceptive and a way to avoid STIs.

Notes

[1] The Family Planning Service Expansion and Technical Support (SEATS) project is a service delivery project supported by USAID and managed by John Snow, Inc., with the overall goal to increase access to quality family planning/reproductive health services for under-served populations.

[2] Sambisa W, Mudzongo P, Muhwava W, Moyo I, Williams T. “Zimbabwe Quick Investigation of Quality of Family Planning.” In *Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports*. MEASURE Evaluation Technical Report Series No.5. Sullivan, Tara M. and Bertrand, Jane T. (Editors). Carolina Population Center, University of North Carolina at Chapel Hill, June 2000.

Does contraceptive discontinuation matter?

by Ann Blanc, Siân Curtis
and Trevor Croft

- ✓ **Fifteen DHS surveys showed that discontinuation of contraceptive methods is a common event.**
- ✓ **Method-specific (or first-method) discontinuation rates are not suitable indicators for monitoring quality of care.**
- ✓ **The all-method discontinuation rate is a better indicator of quality of care than method-specific continuation rates, but with some caveats.**
- ✓ **Contraceptive discontinuation and failure are major factors that contribute to unwanted fertility in high prevalence countries.**

Contraceptive discontinuation is often cited as an outcome associated with the quality of care provided by family planning programs. Therefore, the contraceptive discontinuation rate has been proposed as an indicator for monitoring quality of care, but little work has been done to assess the utility of this indicator as a reflection of the quality of the service environment. In a recent study undertaken by the MEASURE *Evaluation* project, contraceptive histories collected in 15 Demographic and Health (DHS) surveys were used to calculate range of life table measures of discontinuation, including method and reason-specific rates [1]. The 15 countries included in the study represent diverse situations, with overall contraceptive prevalence among married women ranging from 31 to 77%. The most common method is the pill in six countries, the IUD in two countries, female sterilization in six countries, withdrawal in one country, and periodic abstinence in two countries.

Method-specific discontinuation

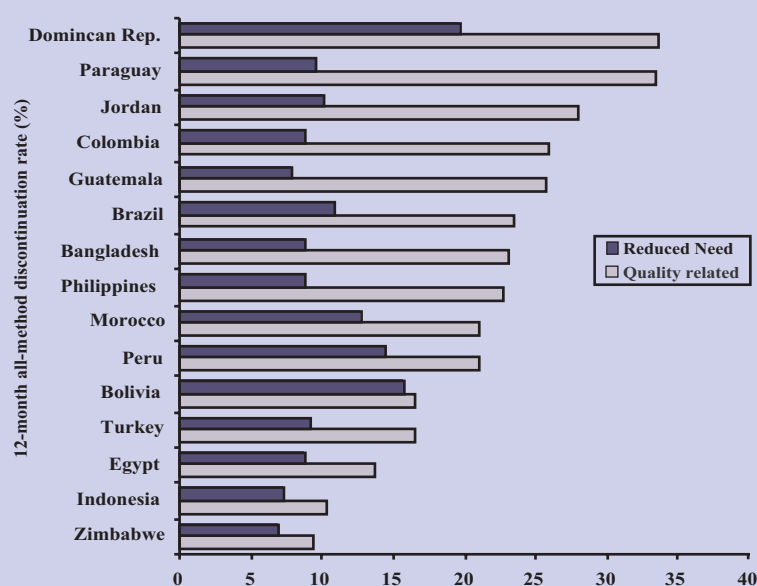
Hormonal methods (pill and injectables) were more likely to be discontinued as a result of side effects or health concerns than were other methods. Except for Zimbabwe, which had very low rates, the percentage discontinuing the pill for these

reasons within a year ranged from 11 to 35%. For injectables, the percentage varied from 15 to 37%. For most countries, the 12-month cumulative rate of discontinuation of the IUD for side effects or health concerns was much lower, varying between 6 and 14%. Other method-related reasons (and contraceptive failure) were more important causes for discontinuation of periodic abstinence, withdrawal, and condoms. Service-related reasons for discontinuation included cost of the method and lack of access to the method. These reasons were rarely mentioned by women as the primary reason for discontinuing use of any method.

Method switching

In all but three countries, between 29 and 59% of women who stopped using a modern, reversible method for a method-related reason switched to a different modern method within three months. Few women returned to the method they had discontinued. In contrast, women who had experienced a contraceptive failure and resumed using contraception after giving birth were most likely to return to the same method.

Figure 1. 12-month cumulative all-method (excluding sterilization) discontinuation rates

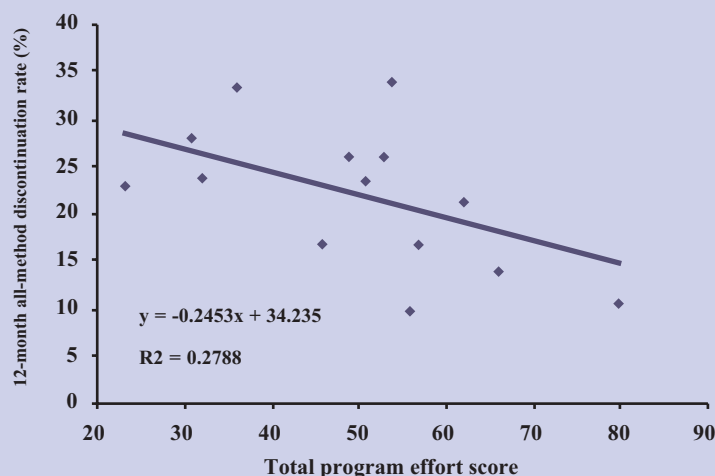


All-method discontinuation rates

A major drawback to method-specific discontinuation rates is that they treat all discontinuations in the same way, regardless of whether the woman subsequently switches to another method or not. All-method discontinuation rates, which measure the rate at which women stop using any method of contraception, are calculated separately for two types of reasons: reduced need (want to get pregnant, infrequent sex/husband away, menopausal/subfecund, and marital dissolution) and quality-related reasons (all other reasons). Overall, between 9% (Zimbabwe) and 34% (Dominican Republic) of women stopped using contraception within 12 months for quality-related reasons (Figure 1). The all-method discontinuation rate for quality-related reasons accounts for between approximately a half and three quarters of the total rate at 12 months.

The all-method rate for quality-related reasons is inversely associated with overall family planning program effort scores; that is, strong programs tend to have relatively low quality-related discontinuation rates (Figure 2) [2]. The relationship between the two indicators is statistically significant, but not particularly strong. The relationship between the all-method discontinuation rate for quality-related reasons and the service related component of the FP program effort score is also negative and statistically significant, but stronger. However, contrary to expectation, two different indicators of method choice are not associated statistically with rates of method discontinuation for quality-related reasons. It appears that higher levels of method choice are associated with more switching between methods. While this may lead to more satisfied clients, it does not appear to lead to consistently lower overall discontinuation rates.

Figure 2. 12-month cumulative all-method discontinuation rates for quality-related reasons by total program effort score



In the 15 countries the total fertility rate (TFR) would be between 4 and 29% lower in the absence of contraceptive failure. The average across all countries is 14%. Without other types of contraceptive discontinuation, the TFR would be reduced by between 20% (Indonesia) and 48% (Jordan). More than half of recent unwanted fertility was due to either a contraceptive failure or a contraceptive discontinuation in all countries except Guatemala. The total unwanted fertility rate would be between about 0.2 and 1.1 births lower in the absence of failure and discontinuation (Figure 3).

Conclusions

The study suggests that the measure of contraceptive discontinuation that most closely approximates an overall indicator of quality of care is the all-method rate for quality related reasons. The advantages of this measure over other types of discontinuation rates are

- 1) The all-method rate focuses on discontinuation of any method of contraception, rather than on a specific method. It thus incorporates the notion that high rates of method switching are not necessarily negatively related to quality. Discontinuation of any method is of greater programmatic interest than discontinuation of a specific method because it leaves women unprotected from the risk of unwanted pregnancy.
- 2) This rate includes only those who discontinued for reasons other than a desire to get pregnant or reduced exposure to pregnancy risk. Many of these reasons are ones that can effectively be addressed by improvements in the family planning program.

One disadvantage of the indicator, revealed by a trend analysis, is that it may not be possible to detect the change in this indicator over five-year periods due to sample sizes in the range utilized by the DHS. In addition, we hesitate to recommend this measure unequivocally as a summary indicator of quality

of care because it does not have a consistent relationship with one of the core components of a high quality service environment — method choice.

Despite some caveats in the use of contraceptive discontinuation rates as an outcome indicator of quality of care, contraceptive discontinuation does matter. Contraceptive discontinuation and failure clearly make a substantial contribution to overall fertility levels and to rates of unwanted fertility in these countries. Therefore, as fertility declines, family planning programs would profit from a shift in emphasis from providing methods to new clients toward providing services to existing clients that may help reduce failure and discontinuation rates. In this context, it is useful to monitor the all-method contraceptive discontinuation rate as an outcome in its own right.

Notes

[1] Blanc, Ann K., Curtis, Siân and Croft, Trevor. *Does Contraceptive Discontinuation Matter? Quality of Care and Fertility Consequences*. MEASURE Evaluation Technical Report Series, No. 3. Carolina Population Center, University of North Carolina at Chapel Hill. November 1999.

[2] Ross, John and Stover, John. *Effort Indices for National Family Planning Programs, 1999 Cycle*. MEASURE Evaluation Working Paper, No. 20. Carolina Population Center, University of North Carolina at Chapel Hill. May 2000.

Figure 3. The contribution of contraceptive failure and discontinuation to the total unwanted fertility rate

